

Pregnancy and Delivery Care

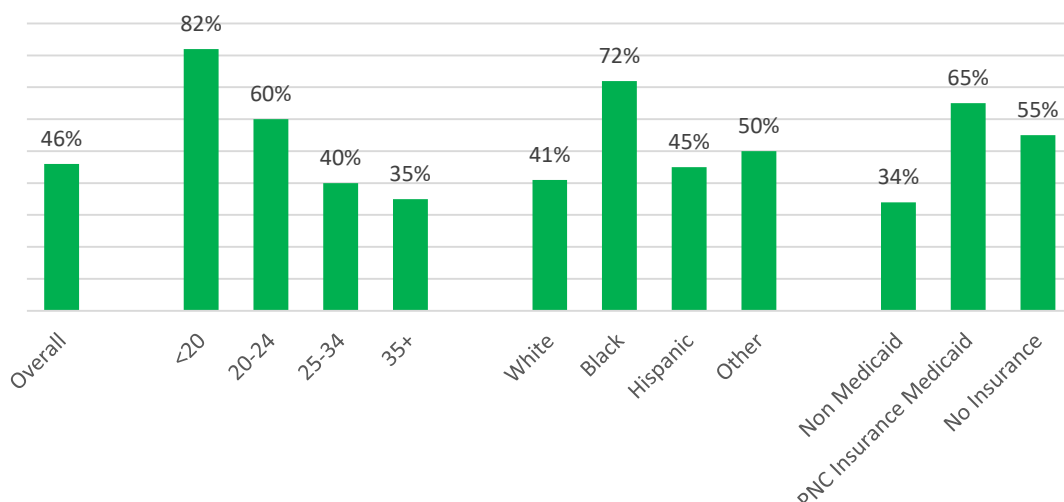
Background

Good health before and during pregnancy is one of the best ways to promote a healthy birth and healthy baby. Prenatal care includes the health care that a pregnant woman receives during her pregnancy to monitor the progression of the pregnancy. Prenatal care in a broader sense may additionally encompass such varied services as mental health care, dental care, and physical therapy, if they are needed. When women receive prenatal care, it offers the opportunity to connect with a care team, ask questions, discuss concerns about their or their child's health, and ensure mental and physical safety during pregnancy and delivery. It also represents a chance for medical providers and others to connect mothers to resources or treatments to improve social, behavioral, or physical outcomes for themselves, their children, and their families. High-quality, coordinated prenatal care, culminating in delivery at a level-appropriate facility, can have lasting effects on the health of mother and baby.

Planned Pregnancies

Children resulting from intended pregnancies have better health at birth and improved long-term health outcomes when compared to children resulting from unintended pregnancies¹. Though the proportion of pregnancies which were unplanned or undesired continues to fall in Missouri, it remains higher than the national average (46% in 2017). The frequency of unplanned pregnancies among Missouri's black population (averaging 71% between 2012-2017) is significantly higher than among the white population (43%). Younger women are also significantly more likely to report that their pregnancies were unplanned or unwanted than were older women, and among women living in households with combined incomes less than \$16,000, nearly 70% of pregnancies were unwanted or unplanned.

Figure 1. Pregnancy Unintendedness by Demographic, MO PRAMS 2016-2017



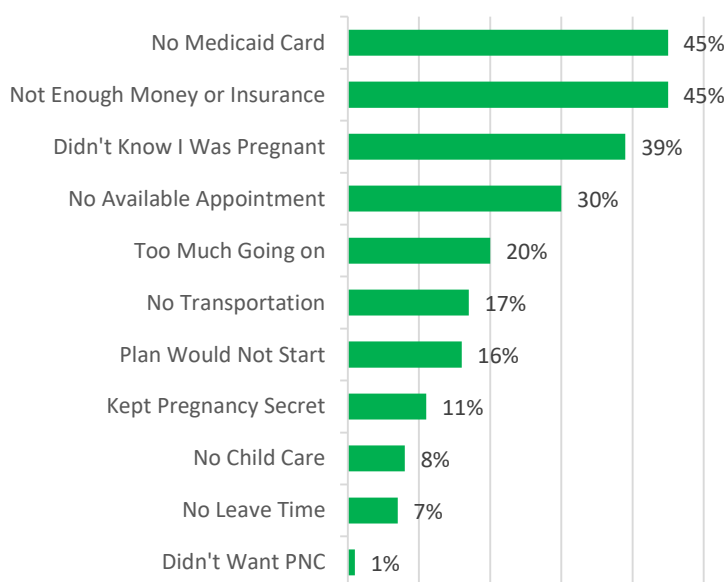
Prenatal Care Adequacy

Research indicates that women who receive no prenatal care are almost three times more likely to give birth to an infant preterm than women who receive prenatal care. The proportion of births to women receiving no prenatal care has more than doubled since 2009, from 0.76% to 1.75%, representing more than 1,200 births in 2018. An even larger proportion of pregnant women received inadequate prenatal care. Prenatal care adequacy is assessed across two dimensions: timely entry into care, and number of prenatal care visits¹. In Missouri, 17% of women received inadequate prenatal care between 2014-2018: prenatal care was considered inadequate for 27% of women with prenatal care paid through MO HealthNet (Medicaid), but for only 10% of those not receiving Medicaid.

“Moving from Illinois to Missouri, I found it a lot more difficult to receive services in this state. I did not even get approval for Medicaid til almost being 5 months pregnant.”

For an uncomplicated pregnancy, entry into care is considered timely if it occurs before the fourth month of pregnancy². Between 2014 and 2018, 27% of Missouri mothers, and 40% of African-American mothers, did not initiate prenatal care in the first trimester. During the same time period, only 32% of women on MO HealthNet began prenatal care during the first trimester³. Among women with late entry into prenatal care, or who received no prenatal care at all, the most commonly-given reasons were related to financial concerns or insurance coverage. Fully 45% of

Figure 2. Barriers to Prenatal Care Among Women With Late or No Prenatal Care, MO PRAMS 2014-2017



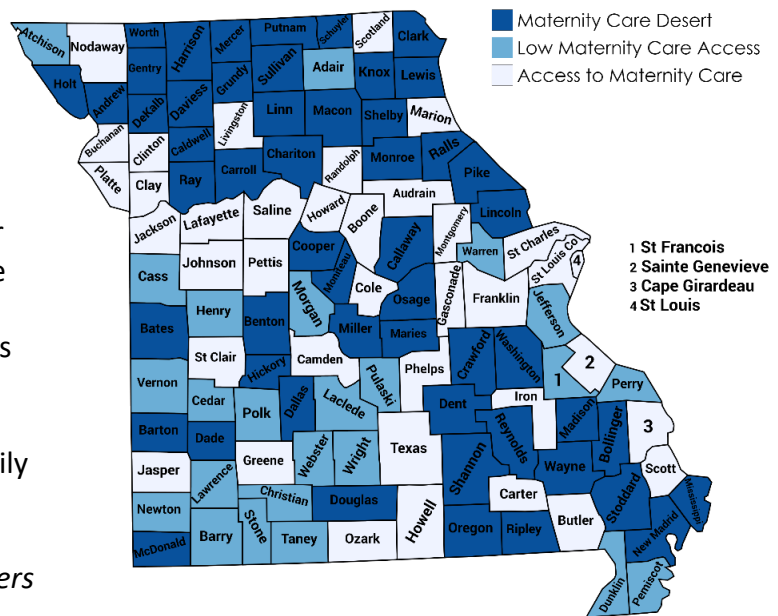
women with late or no prenatal care stated that their delay was related to complications with Medicaid enrollment. An equivalent proportion reported that they postponed care due to financial concerns or other issues with insurance coverage. Additionally, women with unintended pregnancies are less likely to seek or receive prenatal care. Three in ten women who did not receive prenatal care as early as they ultimately wanted to stated that the reason was because they were not aware that they were pregnant⁴.

Ability to physically access prenatal care poses a challenge to nearly one third of women who did not initiate care as early in their pregnancy as desired. Barriers to

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access go beyond issues with transportation, though nearly 17% of women with late/no entry into care reported that transportation represented an obstacle. However, 1 in 12 women reported that their ability to initiate prenatal care was limited by other social factors, including the need to find care for other children, or work schedules or leave policies that prevented them from taking the time to see a physician. Missouri does not mandate that employers offer paid or unpaid sick or family leave to pregnant women, beyond that required by the Family Medical Leave Act (FMLA). Nationally the Department of Labor estimates that two-thirds of employees *work for employers* covered by FMLA, but temporary or short-term workers, contract workers, and non-full-time staff still do not qualify for federally-protected leave. It is estimated that less than half of private sector workers are actually eligible for FMLA⁵.

Figure 3. Maternity Care Deserts in Missouri⁶



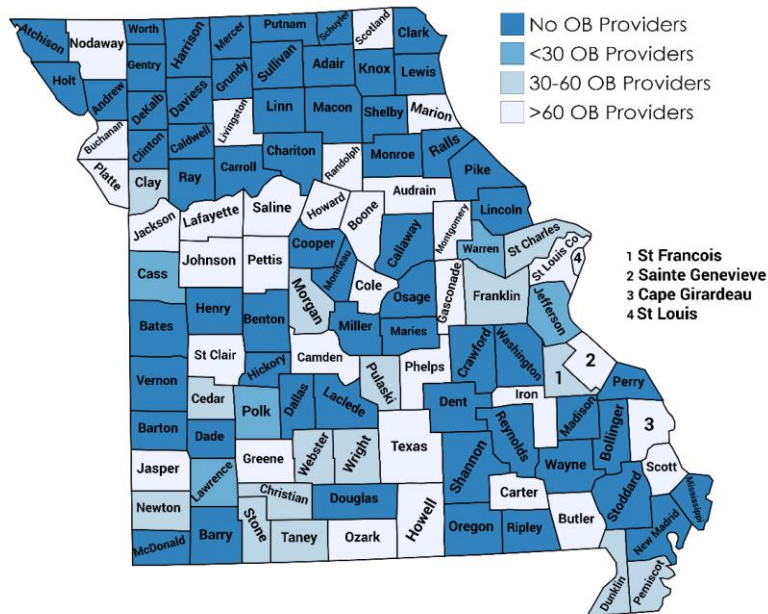
FMLA eligibility requires the following criteria:

- 1. The employee must have been employed with the company for 12 months.***
- 2. The employee must have worked at least 1,250 hours during the 12 months prior to the start of FMLA leave.***
- 3. The employer employs 50 or more employees within a 75-mile radius of the worksite***

Delivery Care

Long travel times to hospitals and a lack of medical providers continue to pose a challenge in Missouri, particularly in rural regions of the state. In Missouri, there are 60 hospitals with at least one obstetric bed, but they are not evenly distributed through the state: 61 counties have no delivery beds. Risk-appropriate perinatal care is associated with decreased morbidity and mortality among mothers and their babies. Risk-appropriate care may address the needs of the mother (levels of maternal care) or the infant (levels of neonatal care). Despite the potential impact on

Figure 4. OB Providers (OB/GYN, CNM) per 10,000 population, Missouri 2016



birth outcomes, some women experience difficulty accessing risk-appropriate care due to limitations of finances, insurance, or physical access. In Missouri in 2018, 87 of very low birth weight (VLBW) infants (infants with weight less than 1500g, or approximately 3.3 pounds) were delivered in a risk-appropriate facility⁷. The remaining 13% born in level I or II hospitals are over 50% more likely to die before discharge than those born at level III+ facilities⁸. Level inappropriate care can also increase risks for the mother, such as increased rates of cesarean deliveries and increased maternal morbidity.

What is Being Done?

Assessing Levels of Care: In 2016, the Missouri legislature passed Senate Bill 50, which amended state statute to mandate that birthing hospitals use the Levels of Care Assessment Tool (LOCATE), developed by CDC, to evaluate and report their level of care to the Department of Health and Senior Services. This effort has enabled DHSS to begin standardizing how levels of care are assessed and improve the ability of MCH partners to understand how level-appropriate care affects birth outcomes.

Maternal-Child Learning Action Network (MC-LAN): The Missouri Hospital Association and supporting partner organizations launched the Missouri Maternal-Child Learning and Action Network in 2018. The MC-LAN is a group of stakeholders from across the state working collaboratively to leverage resources, connect subject matter expertise and drive momentum to reduce maternal and infant morbidity and mortality, and improve the health care experience and outcomes for moms and babies in Missouri.

Alliance on Innovation on Maternal Health (AIM): AIM is a national, data-drive maternal safety and quality improvement initiative. AIM works through state teams and health systems to align national, state, and hospital level quality improvement efforts to improve overall maternal health outcomes. This is primarily accomplished through implementation and data support for AIM-supported Patient Safety Bundles, or a structured way of improving care processes and patient outcomes built upon established best-practices. The Missouri AIM program is currently implementing the “Hypertension in Pregnancy” bundle to address morbidity associated with eclampsia and preeclampsia, and plans to implement the “Obstetric Care for Women with Opioid Use Disorder” bundle beginning in 2021.

Local Public Health Agencies: The Title V program partners with local public health agencies to build systems to promote improved care services for women of childbearing age. Local public health agencies improve access to care by providing pregnancy testing, education, and referral to OB/GYN care (106 agencies), screening clients for insurance or MO HealthNet coverage (106 agencies), assisting eligible women with MO HealthNet enrollment (77 agencies), providing or referring to prenatal case management (70 agencies), and providing education on the importance of prenatal care (96 agencies).

References

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